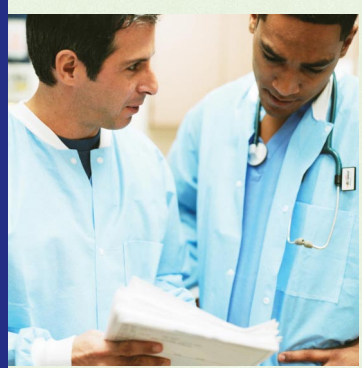
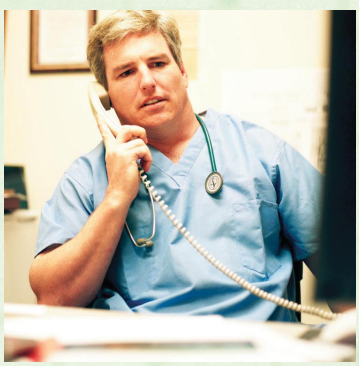
RHODE ISLAND COMMERCIAL HEALTH PLANS' PERFORMANCE REPORT

2003






HQPM

Health Quality Performance Measurement

RI COMMERCIAL HEALTH PLANS' PERFORMANCE REPORT (2003)

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I: EXECUTIVE SUMMARY

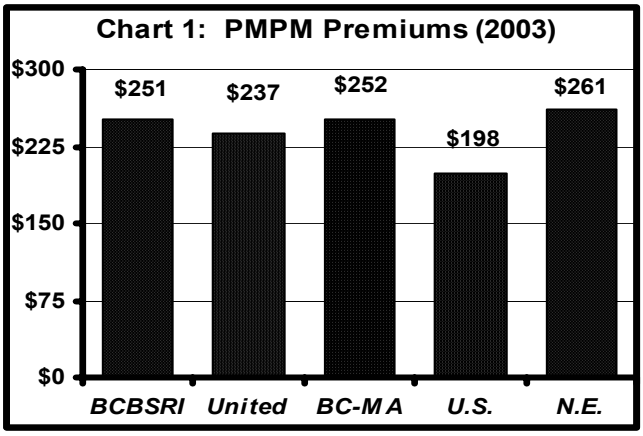
The Health Care Accessibility and Quality Assurance Act passed by the General Assembly in 1996 instituted Health Plan performance reporting in Rhode Island. Since then, RI has become a national leader in this field.[1] 2003 was the sixth year for which data were collected and this Report details those findings and presents comparative performance information, both over time and to national and regional benchmarks.

With the small number of Health Plans in the State and the market dominance of Blue Cross & Blue Shield of RI (BCBSRI), most Rhode Islanders have limited choice of carrier. The lack of selective contracting also means that most Plans provide services through the same network of providers (i.e., the same physicians, hospitals and other providers participate in all Plans). Therefore, the real value in publishing this information is less in aiding consumer choice and more in fostering accountability of the industry. Purchasers deserve to know how well the Plans are performing and policy makers need empirical evidence to set effective policy. An added benefit of this effort is that performance will improve if for no other reason than the results are publicly reported.

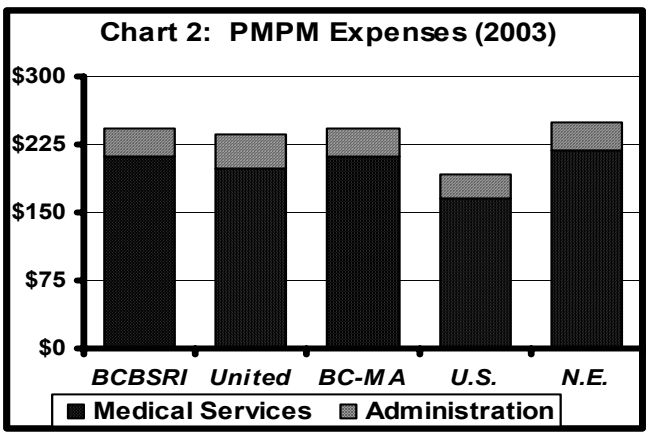
Some 403,000 Rhode Islanders are commercially insured, and this Report analyzes the four largest Health Plans, which together cover 88% of this population. In all, 9 separate dimensions of performance are evaluated. These range from enrollment, finances, and utilization to prevention, screening and treatment, to access, satisfaction and utilization review. A companion publication on Medicare and Medicaid Plans (the *RI Medicare & Medicaid Factbook -2003*) is also available.

RI's Commercial health insurance market is concentrated in two carriers. BCBSRI, including its subsidiary BlueCHiP, has a market share of 64% and UnitedHealthcare of NE controls 18%. Blue Cross of MA has made some inroads, but its share remains in the single digits (7%). The remainder of the market (12%) consists of a host of smaller Plans, none of which has more than 10,000 fully-insured RI members.

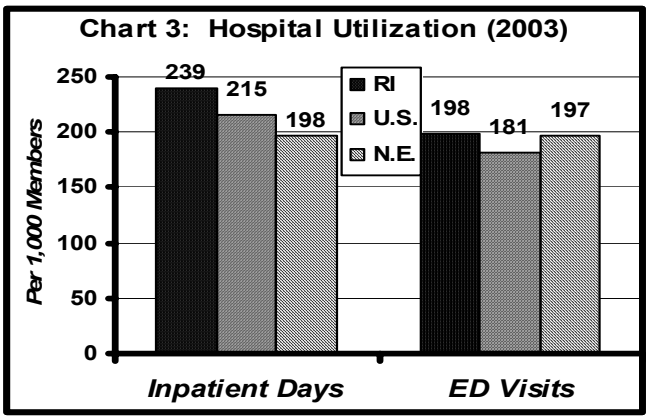
Statewide Health Plan profitability peaked in 2003, with a $8.60 underwriting profit Per Member Per Month (PMPM). This compared favorably to a $6.89 PMPM profit nationally but was less than the $10.72 PMPM profit in New England. Monthly premiums in RI were +25% higher than in the nation ($248 versus $198) but –5% less than in New England ($248 versus $261, -Chart 1[2]).



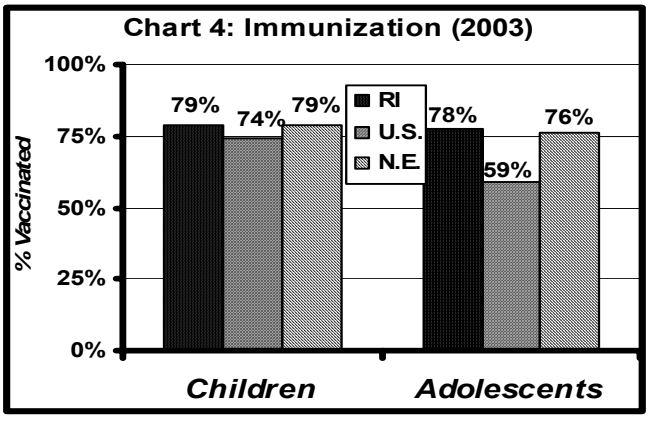
RI Plans spent +26% more on healthcare services for their members than did Plans nationally ($209 PMPM versus $166 PMPM), and slightly less than other New England Plans ($209 versus $219). In addition, local Plans incurred +22% more administrative expenses on a PMPM basis than national Plans ($31.02 versus $25.51), but about the same expenses as their regional counterparts ($31.02 versus $31.52, –Chart 2).



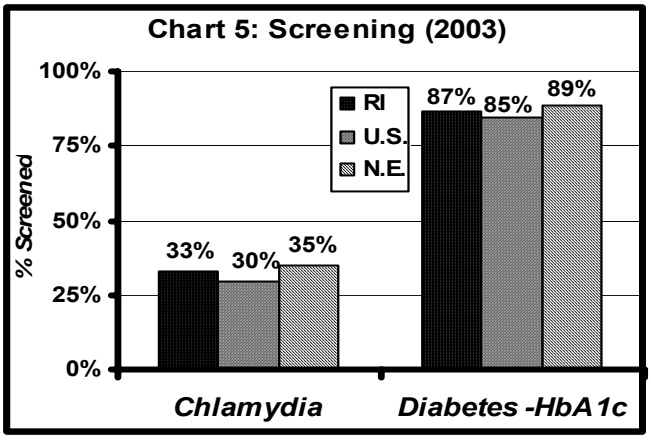
Rhode Islanders' utilization of hospital services was high when compared to regional and national patterns. Inpatient days were significantly above both New England (N.E.) and national rates (+21% and +11%, respectively). In addition, this utilization increased +13% locally in 2003, while the national and regional rates were essentially flat. Emergency Department (ED) utilization was consistent with the NE rate but remained +9% greater than the U.S. rate (Chart 3). Because the patient is not ultimately admitted, this may suggest an inappropriate utilization of the most costly modality for treating non-emergency cases.



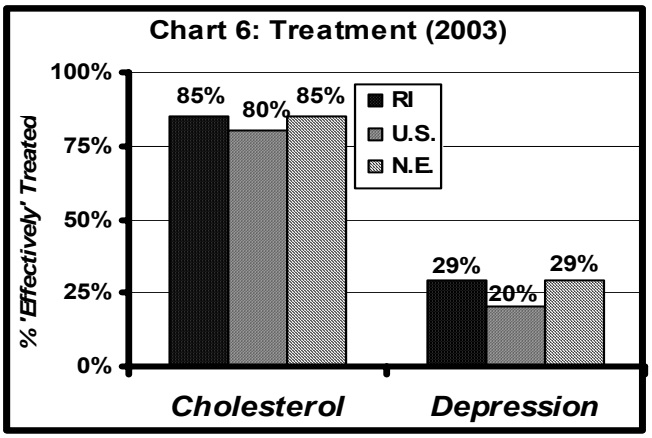
Rhode Island Health Plans performed well at providing preventive services for their members (Chart 4). Immunization is the most cost-effective healthcare activity available, and RI vaccination rates for children and adolescents exceeded those across the country (+6% and +32% higher, respectively). Even though RI rates were similar to those in New England, the fact remains that over 20% of children and adolescents did not receive their vaccinations during the recommended time periods.



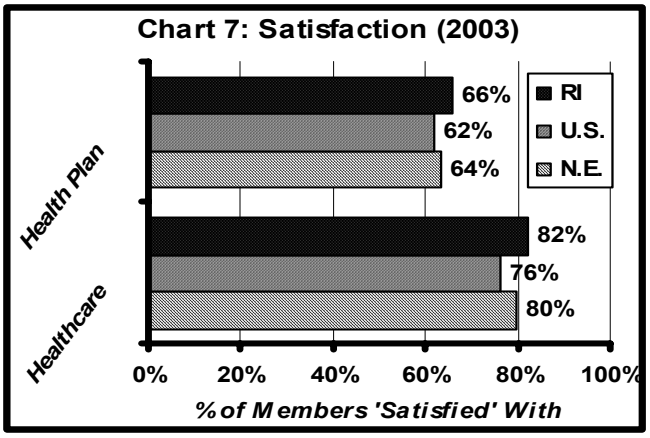
RI Plans' relative performance in disease screening for their members was unremarkable. Screening for disease enables early detection and, especially in the case of cancer, better clinical outcomes. In 2003, RI rates were consistent with both the regional and national benchmarks (Chart 5). Clearly, however, there is room for improvement when over 65% of a population is not screened for disease in the case of Chlamydia.



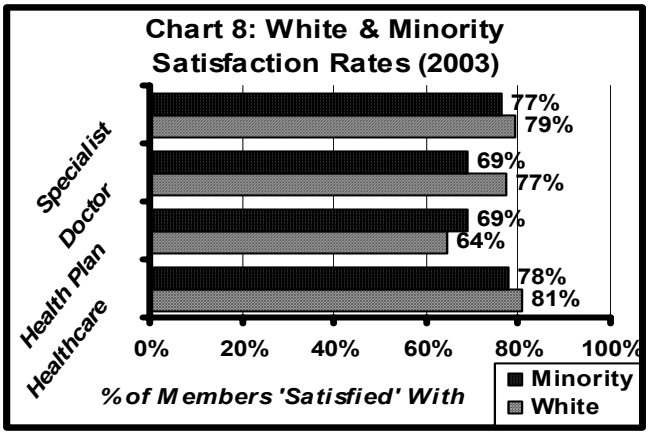
RI Plans were successful at providing 'effective' treatments to their members for a variety of ailments (Chart 6). 'Effective' in this case means that the underlying disease was under control or that treatment was 'optimally' managed. RI's 2003 treatment of cholesterol and depression was superior to the national rates (+5% and +43%, respectively), and equivalent to the regional experience. In addition, RI performance on both measures improved at a faster rate than both cohorts. Again, however, the low absolute rates for Antidepressant Medication Management (depression) should be addressed.



Two thirds of Rhode Islanders were generally satisfied with their Health Plans and four fifths were satisfied with their healthcare (Chart 7). RI's healthcare satisfaction rate was similar to the regional rate, and +8% higher than the national rate. Rhode Islander's satisfaction with their Health Plans was also similar to the regional rate and +7% higher than the national rate. Interestingly, regardless of location, members were more satisfied with their healthcare services than with their Health Plans.



In 2003, Minorities members were almost as satisfied as White members with their healthcare and their specialists (Chart 8). However, Minorities were –11% less satisfied than Whites with their doctors, and +7% more satisfied with their Health Plans.



The real utility in these analyses is in benchmarking performance and promoting quality within the industry. The maxim, *'you can't improve what you can't measure'* holds true.

II: INTRODUCTION

Increasingly, the public, purchasers, providers, and policy makers are seeking meaningful information about Health Plans. This Report provides the most comprehensive public source of data on Health Plans certified to operate in Rhode Island.[3] Consumers and purchasers may use this information to make informed choices among competing Plans or to better understand their chosen Plan. The Plans themselves now have comparative statistics to identify and focus improvement efforts. Policy makers may use this empirical data to support their decision-making.

A. Background

Not all Health Plans are identical. They differ in how they keep members well and how they care for them when they are ill. They also differ in how they provide access to and deliver services. Most Rhode Islanders receive their health coverage through the four commercial Health Plans in this Report, so learning about how they perform is essential to determining if value is received from the premium dollars expended. Consequently, in response to this need for information, the Rhode Island General Assembly passed the Health Care Accessibility and Quality Assurance Act (RIGL 23-17.13) in 1996. One stipulation of this law was that Health Plans submit performance data to the Department of Health (HEALTH).

To consumers, the cost, quality, and access to care provided by a Plan may affect their health. To employers, these same issues may influence worker absenteeism, productivity and the company's personnel costs.

The *RI Commercial Health Plans' Performance Report (2003)* is the sixth annual publication of this information. HEALTH is committed to improving this product, and welcomes all input. For more information on choosing a particular commercial Health Plan, readers are referred to the following Web site: http://hprc.ncqa.org/.

B. How to Use This Information

The Report is divided into Sections containing similar dimensions of performance. Section III examines enrollment and market share. Section IV provides financial data, and Section V compares utilization statistics. Section VI looks at prevention measures, and Section VII provides screening information. Section VIII looks at treatment statistics and Section IX shows access measures. Lastly, Section X gives the results of member satisfaction surveys, and Section IX assesses utilization review statistics. Whenever possible, National (U.S.) and Regional (New England) benchmarks are provided to assess the State's performance relative to these other peer groups.

This Report examines commercial Health Plans only. Similar information on Medicare and Medicaid Plans is presented in a separate publication (the *RI Medicare & Medicaid Factbook -2003*). Different users will use this Report in different ways, however, the following guidelines should help improve its utility.

- **No one measure in and of itself can truly reflect Health Plan performance.** Therefore, the statistics should be viewed in combination and not in isolation.
- **Readers should focus on large differences between Health Plans** that are less likely to be caused by random chance. Generally, differences less than 5% are not considered significant and are not highlighted in this Report.
- **Readers should recognize there may be reasons why results vary other than differences in quality or administration.** Every Plan enrolls a distinct set of members with unique demographic factors that could affect performance (e.g., age, health status, race/ethnicity, socioeconomic status). In addition, differences in covered benefits may also influence outcomes.
- **This Report examines all types of Health Plans (HMOs and PPOs).** HMOs are legally defined and, generally, use provider networks to deliver care through the member's primary care provider. In addition, they may employ a variety of managed care techniques[4] to coordinate

care and control costs. Other types of Plans may use these exact same techniques but are not defined the same way legally, so this distinction becomes less apparent and important.

- **This Report excludes Plans with fewer than 10,000 RI members.** These Plans are fairly inconsequential competitors in the RI marketplace at this time, and to reduce their reporting burden, they are exempt from filing.
- **Comparable benchmark data** (i.e., New England and United States) are from the National Association of Insurance Commissioners' (NAIC) database[5] for Section IV (Finances), and from Quality Compass (National Committee for Quality Assurance), for all other Sections.

III: ENROLLMENT

This Section compares Health Plan membership information and market shares. Included is the fully-insured commercial book-of-business only,[6] and not any self-insured members for which the Plans provide Third Party Administrators' services.

A. RI Enrollment is the computed RI resident enrollment in a Health Plan for the full year. Increasing enrollment over time is important both in terms of "growing the business" and maintaining or increasing market share.

1. RI Enrollment[1]

	2001	2002	2003	'02-'03 Change
BCBSRI	261,075	223,372	204,665	-8%
BlueCHiP	58,803	57,270	51,781	-10%
Combined[2]	319,878	280,642	256,446	-9%
UnitedHealthcare	84,534	63,957	71,277	11%
Blue Cross -MA	27,594	27,732	28,657	3%
Other Plans[3]	42,989	57,294	46,343	-19%
Rhode Island	474,995	429,624	402,723	-6%

[1] *Fully-insured, commercial, Comprehensive business only (RI Member Months / 12)*
[2] *BCBSRI and BlueCHiP Together*
[3] *Other Commercial Plans with <10,000 RI members*

BCBSRI and its subsidiary BlueCHiP, remained, by far, the largest commercial insurers with 256,000 fully-insured RI members. UnitedHealthcare followed with 71,000 RI members, and Blue Cross –MA reported almost 29,000 RI members.

B. RI Market Shares calculates each Plan's percentage of the total RI fully-insured enrollment. In many respects, market share is more important than simple enrollment (although the two are related). It is possible in a shrinking market for a Plan's enrollment to decline while its market share increases. Market share, to a large extent, determines how aggressively a Plan can negotiate provider contracts, rates and commissions, to enhance its competitive position.

2. RI Market Shares

	2001	2002	2003	'02-'03 Change
BCBSRI	55.0%	52.0%	50.8%	-2%
BlueCHiP	12.4%	13.3%	12.9%	-4%
Combined	67.3%	65.3%	63.7%	-3%
UnitedHealthcare	17.8%	14.9%	17.7%	19%
Blue Cross -MA	5.8%	6.5%	7.1%	10%
Other Plans	9%	13%	12%	-14%
Rhode Island	100%	100%	100%	---

BCBSRI (with BlueCHiP) controlled 64% of the commercial market in 2003, down slightly from 67% in 2001. UnitedHealthcare followed with an 18% share, the largest one year gain (+19%). Blue Cross –MA increased its share slightly to 7%.

IV: FINANCES

This Section allows readers to compare information on Health Plan financial operations. Included are the average costs of the Plans (i.e., premium revenue), how much they spent on healthcare services and administration, and how profitable they were from underwriting the healthcare coverage.[7]

A. Premium Revenue is the average monthly amount a Health Plan receives in payment for each member. This is the average cost to

payors for covering one member for one month. Care should be taken in comparing these statistics between Plans. One Plan may be less expensive than another but that doesn't necessarily mean it is a better value. Different Plans may have different benefits, co-pays or deductibles. Therefore, the total healthcare cost for a member in a less expensive Plan may actually be greater than a more expensive Plan that has fewer co-pays, lower deductibles and more covered services the member needs.

3. Premium Revenue *(PMPM)*

	2001	2002	2003	'02-'03 Change
BCBSRI	$219	$233	$255	*10%*
BlueCHiP	$179	$202	$229	*13%*
Combined	$212	$227	$251	*10%*
UnitedHealthcare	$199	$222	$237	*7%*
Blue Cross -MA	$200	$223	$252	*13%*
Rhode Island	$209	$226	$248	*10%*
New England		$236	$261	*11%*
United States		$175	$198	*13%*

The average statewide per member per month (PMPM) cost of Health Plans rose +10% in 2003 to end the period +25% higher than the national benchmark. However, when compared to their New England counterparts, RI Plans were competitively priced. BCBSRI, a Preferred Provider Organization (PPO), continued to cost more than the HMO Plans. PPOs historically sell at a premium to HMOs because they are a less 'managed' product with, generally, less-restrictive networks.

B. Medical Expenses are the amounts Health Plans spend on healthcare services for their members expressed on a PMPM basis. Consumers generally favor higher medical expenses (all else being equal), because it indicates more dollars going into their healthcare. However, lower medical expenses do not necessarily imply that a Plan restricts access to healthcare. Lower expenses could mean that the Plan's members are less ill (i.e., need less services) or that the Plan is more effective at managing care for its members.

4. Medical Expenses *(PMPM)*

	2001	2002	2003	'02-'03 Change
BCBSRI	$187	$203	$218	*7%*
BlueCHiP	$149	$164	$185	*13%*
Combined	$181	$196	$212	*8%*
UnitedHealthcare	$165	$176	$199	*13%*
Blue Cross -MA	$171	$192	$212	*10%*
Rhode Island	$177	$192	$209	*9%*
New England		$201	$219	*9%*
United States		$149	$166	*11%*

Local PMPM medical expenses increased +9% in 2003, ending the period similar to the premium revenue, considerably higher than the U.S. metric (+26% higher), and slightly lower. than the N.E. benchmark. When compared to the national experience, RI's high medical expenses, are not entirely unfavorable nor are they entirely under the control of the Health Plans. PMPM medical expenses are a function of both unit-reimbursement and utilization. While Plans have some discretion to set reimbursement rates, they have, increasingly, less and less direct control over utilization as they abandon many of the managed care tools used in the past.

C. Administrative Expenses are the amounts spent on operating the Health Plan, managing its investments, and marketing its products expressed on a per member per month basis. Many administrative expenses are fixed, so controlling them is essential to maximizing profits.

5. Administrative Expenses *(PMPM)*

	2001	2002	2003	'02-'03 Change
BCBSRI	$24.92	$26.24	$28.08	*7%*
BlueCHiP	$23.49	$30.75	$35.67	*16%*
Combined	$24.67	$27.08	$29.40	*9%*
UnitedHealthcare	$24.63	$31.99	$36.46	*14%*
Blue Cross -MA	$24.28	$25.48	$30.04	*18%*
Rhode Island	$24.63	$27.86	$31.02	*11%*
New England		$27.94	$31.52	*13%*
United States		$22.87	$25.51	*12%*

Following the pattern of the previous three statistics, RI Health Plans' administrative expenses were significantly higher than the national benchmark (+22%) and marginally lower than the N.E. benchmark. Interestingly,

in 2001, BCBSRI had the highest administrative costs of all Plans, but it ended the period in 2003 with the lowest administrative costs. Even on a combined basis with its subsidiary BlueCHiP, this same situation held true.

D. Underwriting Profits are the per member per month net amounts generated from insuring the commercial book-of-business after all associated expenses have been paid. This statistic reflects the operating profitability of the product line and how financially solvent it is. Members in an unprofitable Plan may find themselves facing above-market price increases or compromised customer service and coverage. Likewise, providers participating in an unprofitable Plan could experience delinquent payments or outright default.

6. Underwriting Profit/Loss *(PMPM)*

	2001	2002	2003	'02-'03 Change
BCBSRI	$6.85	$4.08	$9.42	*131%*
BlueCHiP	$7.15	$7.10	$8.10	*14%*
Combined	$6.90	$4.64	$9.19	*98%*
UnitedHealthcare	$10.04	$13.67	$6.33	*-54%*
Blue Cross -MA	$3.68	$5.55	$9.34	*68%*
Rhode Island	$7.31	$6.30	$8.60	*37%*
New England		$7.98	$10.72	*34%*
United States		$3.50	$6.89	*97%*

In 2003, there was a significant increase in RI underwriting profits (+37%), with every Plan (except for UnitedHealthcare), posting a gain from the previous year, and BCBSRI more than doubling its value. Statewide profitability ended –20% less than the regional comparable and +25% higher than the national comparable in 2003.

V: UTILIZATION

This Section gives HEDIS[8] information on the services a Health Plan provides to its members.

A. Hospital Discharges are the average number of acute-care hospital discharges (excluding substance abuse, mental health and newborn discharges) used by every 1,000 members in a Plan.

7. Hospital Discharges *(per 1,000)*

	2001	2002	2003	'02-'03 Change
BCBSRI	49.7	53.7	57.2	*7%*
BlueCHiP	47.4	53.2	53.3	*0%*
UnitedHealthcare	55.5	47.7	53.2	*12%*
Blue Cross -MA	47.0	48.3	49.6	*3%*
Rhode Island	50.3	52.2	55.2	*6%*
New England	50.2	50.3	51.4	*2%*
United States	56.8	57.1	58.2	*2%*

RI's hospital discharge rate increased +6% in 2003 and ended the period +7% higher than the New England rate, but both RI's and N.E.'s discharge rates were lower than the national benchmark.

B. Hospital Days are the average number of acute-care hospital days used by every 1,000 members in a Plan. Excluded are substance abuse, mental health and newborn days.

8. Hospital Days *(per 1,000)*

	2001	2002	2003	'02-'03 Change
BCBSRI	205	214	251	*17%*
BlueCHiP	194	226	238	*5%*
UnitedHealthcare	210	193	219	*13%*
Blue Cross -MA	200	206	209	*2%*
Rhode Island	204	212	239	*13%*
New England	196	197	198	*1%*
United States	211	209	215	*3%*

Hospital day utilization was a different situation than discharges. RI's day use spiked +13% in 2003 causing in-state utilization to exceed both the regional and U.S. rates (+21% and +11%, respectively).

C. Average Length of Stay is the average number of inpatient days for each acute-care hospital admission.

9. Average Length of Stay

	2001	2002	2003	'02-'03 Change
BCBSRI	4.1	4.0	4.4	*10%*
BlueCHiP	4.1	4.3	4.5	*5%*
UnitedHealthcare	3.8	4.1	4.1	*0%*
Blue Cross -MA	4.3	4.3	4.2	*-2%*
Rhode Island	4.1	4.1	4.3	*6%*
New England	3.9	3.9	3.8	*-2%*
United States	3.7	3.7	3.7	*1%*

Clearly, with RI's day utilization increasing faster than its discharge utilization, one expects lengths of stay to increase in kind. With the statewide ALOS hitting 4.3 days in 2003, RI was +13% above the N.E. metric and +18% above the U.S. benchmark. Comparison of all-payor and Medicare case-mix data[9] suggest that RI's longer stays were, at least, partially warranted because of the complexity of its patients compared to patients elsewhere.

D. ED Visits is the number of visits to the Hospital Emergency Department (that did not result in the patient being admitted) for every 1,000 members in a Plan. Emergency rooms are often used to provide primary or secondary care that could be delivered more cost-effectively and more properly elsewhere.

10. ED Visits *(per 1,000)*

	2001	2002	2003	'02-'03 Change
BCBSRI	198	203	197	-3%
BlueCHiP	187	196	197	1%
UnitedHealthcare	177	195	200	3%
Blue Cross -MA	210	202	204	1%
Rhode Island	193	201	198	-1%
New England	192	201	197	-2%
United States	176	183	181	-1%

Both N.E. and RI have struggled with ER utilization rates that have consistently been ~+10% higher than the U.S. rates. This may be endemic to the region, however, given its historical practice patterns and lack of significant primary care group practices, at least in RI.

VI: PREVENTION

This Section contains HEDIS measures that look at how effectively a Plan delivers preventive services to keep its members healthy.

A. Childhood Immunization is the percentage of children in the Plan who received the appropriate immunizations[10] by age 2. As immunizations protect children against preventable and sometimes devastating disease, they are one of the most cost-effective examples of high-quality primary care.

11. Childhood Immunization

	2001	2002	2003	'02-'03 Change
BCBSRI	72.3%	83.0%	79.6%	-4%
BlueCHiP	71.5%	80.6%	77.0%	-4%
UnitedHealthcare	80.5%	70.3%	73.9%	5%
Blue Cross -MA	89.1%	87.6%	88.9%	1%
Rhode Island	74.8%	80.8%	78.8%	-2%
New England	80.5%	78.0%	79.0%	1%
United States	70.1%	68.6%	74.4%	9%

RI's 2003 child immunization rate declined while the N.E. and U.S. rates improved, but the state remained +6% higher than the U.S. benchmark and equivalent to the regional experience. UnitedHealthcare had a comparatively low rate in 2002, but it posted the biggest improvement in 2003 (+5%). Clearly, with over 20% of commercially insured RI children not receiving their vaccinations within the recommended timeframes, there needs to be renewed effort to reach this population.

B. Adolescent Immunization is the percentage of adolescents (turning 13) who received the appropriate immunizations.[11] Adolescent immunizations are a proven defense against common, serious and transmissible diseases such as Hepatitis B, measles, mumps and rubella.

12. Adolescent Immunization

	2001	2002	2003	'02-'03 Change
BCBSRI	62.3%	71.8%	77.6%	8%
BlueCHiP	64.7%	80.5%	81.5%	1%
UnitedHealthcare	65.9%	58.4%	72.5%	24%
Blue Cross -MA	58.6%	80.5%	85.7%	6%
Rhode Island	63.1%	71.5%	77.8%	9%
New England	60.6%	72.2%	76.0%	5%
United States	44.8%	50.1%	58.7%	17%

RI Health Plans improved their adolescent immunization rates, and finished equivalent to the N.E. experience, and +32% higher than the U.S. rate. UnitedHealthcare, again had a comparatively low rate in 2002, but its performance improved greatly in 2003 (+24%). Similar to the childhood immunization rates, there needs to be continued progress in getting

the 22%+ of this population immunized within the recommended timeframes.

C. Advising Smokers to Quit is the percentage of members (age 18+) who are smokers or recent quitters who received advice to quit. Smoking is the leading preventable cause of death in the nation (~400,000 deaths per year).

13. Advising Smokers to Quit

	2001	2002	2003	'02-'03 Change
BCBSRI	76.3%	72.9%	78.3%	*7%*
BlueCHiP	75.6%	69.5%	71.9%	*3%*
UnitedHealthcare	n/a	39.2%	65.4%	*67%*
Blue Cross -MA	71.0%	70.5%	73.1%	*4%*
Rhode Island	75.8%	66.4%	74.4%	*12%*
New England	71.8%	73.3%	73.4%	*0%*
United States	66.2%	67.7%	68.7%	*1%*

RI' relative position on this measure improved to exceed the national benchmark (+8%) and to approximate the regional benchmark. Once again, UnitedHealthcare posted a comparatively low rate in 2002, but it showed significant gains in 2003 (+67%). Given the marginal cost to provide healthcare advice on smoking, a statewide rate less than 75% is unacceptable.

VII: SCREENING

This Section contains HEDIS measures that examine how effectively a Plan screens its members for possible medical problems.

A. Breast Cancer Screening is the percentage of women members (age 52-69) who had a mammogram within the last two years. Breast cancer is the second most prevalent cancer among women (180,000 new cases per year), and mammography screening reduces mortality 20-30%.

14. Breast Cancer Screening

	2001	2002	2003[1]	'02-'03 Change
BCBSRI	76.2%	76.9%	76.9%	---
BlueCHiP	76.0%	80.4%	80.4%	---
UnitedHealthcare	78.5%	78.4%	78.4%	---
Blue Cross -MA	80.0%	81.5%	83.1%	*2%*
Rhode Island	76.9%	78.0%	78.2%	---
New England	81.4%	80.8%	80.9%	*0%*
United States	75.9%	74.9%	75.3%	*0%*

[1] *Plans had option of reporting previous year's values*

RI's breast cancer screening rates were unremarkable when compared to national and regional rates, however, a rate below 80% shows need for improvement.

B. Cervical Cancer Screening is the percentage of women (21-64) who received a Pap test within three years. Over 4,000 women die each year from cervical cancer in the U.S., and Pap tests are the primary method for early detection.

15. Cervical Cancer Screening

	2001	2002	2003[1]	'02-'03 Change
BCBSRI	79.9%	82.6%	82.6%	---
BlueCHiP	84.2%	87.5%	87.5%	---
UnitedHealthcare	80.9%	82.9%	82.9%	---
Blue Cross -MA	85.9%	89.0%	89.0%	---
Rhode Island	81.1%	83.9%	83.9%	---
New England	85.7%	85.7%	86.6%	*1%*
United States	81.2%	80.5%	81.8%	*2%*

[1] *Plans had option of reporting previous year's values*

RI's relative performance on this measure was unremarkable when compared to the N.E. and U.S. benchmarks.

C. Chlamydia Screening is the percentage of women members (age 16-25) having a chlamydia test during the year. Chlamydia is the most common sexually transmitted disease (~3 million infected annually) and screening is essential because the disease is asymptomatic.

16. Chlamydia Screening	2001	2002	2003[1]	'02-'03 Change
BCBSRI	25.7%	25.3%	30.4%	20%
BlueCHiP	26.0%	29.8%	36.1%	21%
UnitedHealthcare	23.2%	29.4%	33.7%	15%
Blue Cross -MA	32.1%	35.6%	39.8%	12%
Rhode Island	25.7%	27.5%	32.6%	19%
New England	25.1%	28.9%	34.7%	20%
United States	21.6%	25.4%	29.7%	17%

[1] *Calculation of this statistic changed in 2003, so care should be exercised in comparing 2002-2003 trends*

Every RI Health Plan increased its performance on this measure, but the statewide statistic finished –6% below the N.E. benchmark and +10% above the U.S. benchmark in 2003. The low absolute values both locally and nationally, illustrate the need for further improvement in this screening.

D. Diabetes Care –Eye Exam Screening is the percentage of members (age 18-75) with diabetes that received an eye exam for retinal disease. Diabetes is the leading cause of adult blindness in the US, so regular examinations are important to diagnose problems as early as possible.

17. Diabetes -Eye Exam Screening	2001	2002	2003[1]	'02-'03 Change
BCBSRI	51.3%	51.6%	53.5%	4%
BlueCHiP	57.9%	61.3%	58.9%	-4%
UnitedHealthcare	63.0%	56.0%	58.9%	5%
Blue Cross -MA	65.0%	63.5%	63.5%	---
Rhode Island	55.4%	54.7%	56.2%	3%
New England	64.6%	62.3%	59.9%	-4%
United States	52.2%	51.7%	48.8%	-6%

[1] *Plans had option of reporting previous year's values, and calculation of this statistic changed in 2003, so care should be exercised in comparing 2002-2003 trends*

Even though the statewide performance improved in 2003 while the national and regional metrics declined, RI remained –6% below the N.E. benchmark, but +15% above the U.S. benchmark. The low absolute values both locally and nationally, illustrate the need for further improvement in eye screening.

E. Diabetes Care –HbA1c Screening is the percentage of diabetic members (age 18-75) who had their hemoglobin A1c tested. Diabetes is one of the most costly (~$100 billion annually), and prevalent (~17 million) diseases in the U.S. Complications from diabetes can only be prevented or controlled when physicians and patients focus on controlling HbA1c levels, and screening is the first part of this process.

18. Diabetes Care -HbA1c Tested	2001	2002	2003	'02-'03 Change
BCBSRI	86.4%	84.7%	85.9%	1%
BlueCHiP	89.3%	89.8%	87.8%	-2%
UnitedHealthcare	73.2%	81.8%	86.1%	5%
Blue Cross -MA	87.6%	88.3%	89.5%	1%
Rhode Island	84.3%	85.3%	86.5%	1%
New England	85.7%	87.6%	88.6%	1%
United States	81.5%	82.6%	84.6%	2%

RI performance on this measure was essentially flat over time, and similar to the to the regional and national experience in 2003.

VIII: TREATMENT

This Section contains HEDIS measures that look at the clinical quality of care provided within a Health Plan, how well it treats its members who are ill and whether that care is effectively managing the disease.

A. Controlling High Blood Pressure is the percentage of hypertensive members (age 46-85) whose blood pressure was under control. Approximately 30% of the adult population has hypertension and control of this disease can reduce mortality from stroke, heart disease and renal failure.

19. Controlling High Blood Pressure	2001	2002	2003[1]	'02-'03 Change
BCBSRI	60.1%	74.2%	74.2%	---
BlueCHiP	61.8%	69.9%	69.9%	---
UnitedHealthcare	63.3%	55.5%	61.8%	11%
Blue Cross -MA	57.2%	67.7%	73.0%	8%
Rhode Island	60.8%	69.8%	71.0%	2%
New England	60.3%	64.6%	66.6%	3%
United States	55.8%	58.4%	62.2%	7%

[1] *Plans had option of reporting previous year's values*

RI Plans performed relatively well on this measure, besting the regional and national benchmarks (+7% and +14%, respectively). However, any treatment regimen in which almost 30% of the affected population is not responding needs to be addressed.

B. Beta Blocker Treatment is the percentage of members (age 35+) discharged after an acute myocardial infarction (MI) who received an outpatient beta blocker prescription at discharge. Given the prevalence (>1 million MIs annually), and costs of heart disease in the U.S. (~$111 billion annually), beta blocker therapy has proven an effective medical treatment to reduce the risk of having another attack.

20. Beta Blocker Treatment

	2001	2002	2003	'02-'03 Change
BCBSRI	90.8%	97.7%	92.5%	-5%
BlueCHiP	96.1%	98.2%	96.2%	-2%
UnitedHealthcare	85.2%	97.5%	91.7%	-6%
Blue Cross -MA	97.0%	99.0%	96.8%	-2%
Rhode Island	90.8%	97.8%	93.2%	-5%
New England	95.8%	97.4%	97.2%	0%
United States	92.8%	93.5%	94.3%	1%

RI Plans performed consistent with their regional and national peers on this measure, however, there was an unfavorable decline of –5% statewide in 2003.

C. Cholesterol Management is the percentage of members (age 18-75) discharged after an acute cardiac event whose LDL-C was controlled to <130mg/dL between 60 and 365 days after discharge. Coronary artery disease (CAD) affects ~15 million Americans and claims ~1 millions lives each year. Total blood cholesterol is directly related to CAD (and heart disease), so management of this causative factor is important in controlling the disease.

21. Cholesterol Management

	2001	2002	2003	'02-'03 Change
BCBSRI	80.5%	79.1%	85.2%	8%
BlueCHiP	80.5%	82.7%	89.2%	8%
UnitedHealthcare	80.4%	80.0%	78.9%	-1%
Blue Cross -MA	82.2%	89.7%	87.6%	-2%
Rhode Island	80.6%	80.6%	84.7%	5%
New England	82.0%	83.9%	85.3%	2%
United States	77.4%	79.4%	80.3%	1%

RI performance was equivalent to the regional experience and slightly better (+5%) than the national experience. Improvement in 2003, however, was greater in RI than elsewhere.

D. Diabetes Care –HbA1c Controlled is the percentage of diabetic members (age 18-75) whose blood sugar was under control (i.e., <9.0%). This statistic is the complement of the HEDIS Diabetes Care –HbA1c Not Controlled statistic. Diabetes affects ~17 million Americans and causes 20% of all deaths in adults over 25. In addition, its complications (amputations, kidney failure, blindness) may be prevented if diagnosed and addressed early.

22. Diabetes -HbA1c Controlled[1]

	2001	2002	2003[2]	'02-'03 Change
BCBSRI	36.0%	56.2%	63.7%	13%
BlueCHiP	44.5%	68.9%	71.5%	4%
UnitedHealthcare	59.6%	55.5%	60.6%	9%
Blue Cross -MA	66.4%	74.2%	76.2%	3%
Rhode Island	43.7%	59.4%	65.2%	10%
New England	67.0%	72.5%	72.4%	0%
United States	63.7%	66.1%	68.1%	3%

[1] This statistic is the complement of the HEDIS Diabetes Care -HbA1c NOT controlled measure
[2] Calculation of the HEDIS statistic changed in 2003, so care should be exercised in comparing 2002-2003 trends

RI Plans performed poorly on this measure in relation to the regional (-11% lower) benchmark. Clearly more progress is needed with almost 35% of diabetics not controlled.

E. Antidepressant Medication Management is the percentage of members (age 18+) with a new episode of depression, receiving medication and at least three provider contacts within 12 weeks. Depression is a major quality

of life factor, and has huge societal costs in terms of absenteeism and productivity.

23. Antidepressant Medication Mgmt	2001	2002	2003[1]	'02-'03 Change
BCBSRI	25.7%	23.4%	29.4%	26%
BlueCHiP	21.9%	19.6%	24.0%	22%
UnitedHealthcare	25.3%	25.3%	27.3%	8%
Blue Cross -MA	30.0%	38.7%	38.7%	0%
Rhode Island	25.4%	24.3%	28.9%	19%
New England	25.8%	26.2%	29.4%	13%
United States	20.6%	19.2%	20.3%	6%

[1] *Calculation of this statistic changed in 2003, so care should be exercised in comparing 2002-2003 trends*

RI's low values on this measure were matched by equally low benchmarks, so the state did relatively well at least when compared to the national rate (+43% higher). However, a situation where almost 3 of 4 patients are not getting the recommended treatment is not favorable.

IX: ACCESS

The HEDIS measures in this Section examine if members are obtaining needed services from the healthcare system. Access is one of the most difficult concepts to measure. It is more than simply making healthcare services available. Access means the right patients get the right care in the right amounts at the right time. Most of these measures are proxies for gauging access to particular services.

A. Follow-up for Mental Illness measures the percentage of members (age 6+) who were discharged and received a follow-up visit within 30 days. Follow-up to hospitalization for mental illness is important to transitioning the patient out of the inpatient setting and for evaluating medications.

24. Follow-up for Mental Illness	2001	2002	2003[1]	'02-'03 Change
BCBSRI	68.7%	69.7%	78.3%	12%
BlueCHiP	65.5%	65.8%	75.3%	14%
UnitedHealthcare	72.6%	73.7%	73.7%	---
Blue Cross -MA	86.9%	89.4%	83.5%	-7%
Rhode Island	70.2%	71.3%	77.4%	9%
New England	81.4%	81.4%	82.5%	1%
United States	72.2%	73.6%	74.4%	1%

[1] *Plans had option of reporting previous year's values*

RI Plans improved their performance in 2003 (+9%) to finish the period –6% below the N.E. metric and equivalent to the U.S. metric. Regardless of this favorable trend, the fact remains that over 20% of Rhode Islanders who could benefit from these services are not receiving them.

B. Prenatal Care Access measures the percentage of women who delivered a live birth and had a prenatal visit in the first trimester. Prenatal care is preventive care, both in terms of avoiding poor outcomes and preparing the woman to become a mother.

25. Prenatal Care Access	2001	2002	2003[1]	'02-'03 Change
BCBSRI	83.7%	82.8%	82.8%	---
BlueCHiP	91.8%	93.2%	93.2%	---
UnitedHealthcare	87.1%	81.3%	81.3%	---
Blue Cross -MA	96.7%	98.0%	98.0%	---
Rhode Island	86.3%	85.3%	85.2%	---
New England	93.7%	92.7%	94.5%	2%
United States	87.4%	86.7%	89.4%	3%

[1] *Plans had option of reporting previous year's values*

RI Plans performed less well on this measure when compared to the national and regional benchmarks both in 2002 and 2003.

C. Postpartum Care Access measures the percentage of women who delivered a live birth and had a postpartum visit between 21-56 days after delivery. Postpartum care is essential in terms of evaluating the mother's physical and emotional well-being at a time of great stress and change.

26. Postpartum Care Access	2001	2002	2003[1]	'02-'03 Change
BCBSRI	77.1%	79.4%	79.4%	---
BlueCHiP	77.1%	84.1%	84.1%	---
UnitedHealthcare	81.7%	77.4%	77.7%	*0%*
Blue Cross -MA	87.5%	87.8%	87.8%	---
Rhode Island	78.7%	80.4%	80.4%	---
New England	84.6%	82.5%	85.0%	*3%*
United States	78.7%	77.0%	80.3%	*4%*

[1] *Plans had option of reporting previous year's values*

RI's values on this measure were unremarkable when compared to the regional and national benchmarks.

D. Well Child Visits measures the percentage of members (age 3-6) who received a primary care visit during the year. Well child visits are critical in detecting vision, speech and language problems early to help each child reach his or her full potential.

27. Well Child Visits	2001	2002	2003	'02-'03 Change
BCBSRI	80.7%	78.6%	78.1%	*-1%*
BlueCHiP	79.7%	80.7%	80.8%	*0%*
UnitedHealthcare	78.5%	80.4%	82.0%	*2%*
Blue Cross -MA	90.0%	91.3%	89.5%	*-2%*
Rhode Island	80.7%	80.2%	80.2%	*0%*
New England	77.3%	79.2%	81.6%	*3%*
United States	59.7%	60.4%	62.7%	*4%*

RI rates were equivalent to the regional rates and considerably higher than the national rates over the period (+28% higher in 2003).

E. Adolescent Well-Care Visits measures the percentage of members (age 12-21) who received a well-care visit during the year. Well-care visits are key to addressing the physical, emotional and social aspects of development in this population transitioning from childhood to adulthood.

28. Adolescent Well-Care Visits	2001	2002	2003	'02-'03 Change
BCBSRI	53.7%	57.6%	58.6%	*2%*
BlueCHiP	53.6%	54.8%	60.3%	*10%*
UnitedHealthcare	52.6%	53.1%	56.3%	*6%*
Blue Cross -MA	63.7%	68.2%	69.2%	*1%*
Rhode Island	54.1%	57.2%	59.2%	*4%*
New England	49.9%	53.0%	54.7%	*3%*
United States	33.6%	35.8%	37.1%	*4%*

RI had superior results on this measure than either the N.E. region or the U.S. in general. In fact, the local rate was +60% higher than the national benchmark. However, a full 2 out of 5 RI adolescents in this population are still not accessing these services.

F. Mental Health Access is the percentage of members receiving any mental health treatment (i.e., inpatient, day/night or ambulatory) during the year. Mental illness is widely under-diagnosed and a major quality-of-life determinant.

29. Mental Health Access	2001	2002	2003	'02-'03 Change
BCBSRI	9.0%	10.0%	10.1%	*1%*
BlueCHiP	8.6%	8.3%	9.1%	*10%*
UnitedHealthcare	7.6%	7.5%	8.6%	*15%*
Blue Cross -MA	9.0%	9.7%	10.4%	*7%*
Rhode Island	8.7%	9.3%	9.7%	*4%*
New England	7.4%	8.0%	7.8%	*-3%*
United States	5.4%	5.3%	5.4%	*2%*

Behavioral health (mental health and substance abuse) access is a bright spot for the state. RI's mental health access continued to outpace both the regional rate (+54% higher) and the national rate (+79% higher). However, without knowing the comparative incidence rates for mental illness and the actual utilization of services, one cannot conclude that appropriate mental health treatment was any better in RI than elsewhere, only that a greater percentage of RI members accessed these services at least once.

G. Substance Abuse Access is the percentage of members receiving substance abuse treatment services (i.e., inpatient, day/night or ambulatory) during the year.

Substance abuse is very expensive in terms of personal and societal costs. Treatment, even considering recidivism rates, remains the most cost-effective response to this disease.

30. Substance Abuse Access	2001	2002	2003	'02-'03 Change
BCBSRI	0.81%	0.80%	0.80%	0%
BlueCHiP	0.78%	0.80%	1.00%	25%
UnitedHealthcare	0.50%	0.60%	0.70%	17%
Blue Cross -MA	0.39%	0.50%	0.60%	20%
Rhode Island	0.72%	0.74%	0.79%	7%
New England	0.51%	0.49%	0.48%	-2%
United States	0.37%	0.37%	0.37%	0%

RI's substance abuse access continued to outpace both the regional rate (+65% higher) and the national rate (+114% higher). However, like mental health, without knowing the comparative incidence rates for substance abuse and the actual utilization of services, one cannot conclude that substance abuse treatment was any better in RI than elsewhere, only that a greater percentage of RI members accessed these services at least once.

X: SATISFACTION

This Section provides CAHPS[12] information on the percentage of members who were satisfied with their experience of care, and statewide satisfaction rates by racial status.

A. Ratings of Healthcare are the percentages of members indicating overall satisfaction with all of the healthcare services received in the past year.

31. Satisfaction with Healthcare	2001	2002	2003	'02-'03 Change
BCBSRI	80.1%	80.3%	83.7%	4%
BlueCHiP	73.3%	80.8%	79.0%	-2%
UnitedHealthcare	79.1%	80.7%	80.6%	0%
Blue Cross -MA	78.0%	76.0%	79.9%	5%
Rhode Island	78.8%	80.1%	82.1%	2%
New England	77.5%	79.0%	79.6%	1%
United States	74.0%	75.1%	76.3%	1%

This is a significant satisfaction measure in that it provides a composite score of overall satisfaction with all of the healthcare services a member receives. In 2003, the statewide satisfaction with healthcare rate was essentially equivalent to the regional rate and +8% higher than the national rate.

B. Ratings of Health Plans are the percentages of members indicating overall satisfaction with the Health Plan itself.

32. Satisfaction with Health Plans	2001	2002	2003	'02-'03 Change
BCBSRI	69.2%	72.3%	72.2%	0%
BlueCHiP	61.2%	54.6%	49.7%	-9%
UnitedHealthcare	67.4%	66.9%	57.8%	-14%
Blue Cross -MA	74.0%	72.0%	71.6%	-1%
Rhode Island	68.0%	68.6%	66.0%	-4%
New England	64.9%	64.0%	63.5%	-1%
United States	61.7%	61.3%	61.8%	1%

This is another composite measure examining how members viewed the Health Plan itself. In 2003, the statewide satisfaction rate was equivalent to the regional rate and 7% higher than the national rate. BlueCHiP and UnitedHealthcare posted comparatively low satisfaction rates in 2003, of 50% and 58%, respectively.

C. 2003 White & Minority Satisfaction Rates are the 2003 statewide White and Minority satisfaction rates for different aspects of care. The value in this exercise is to illuminate any differences in satisfaction experienced by Minority members. Minority members are an aggregate of all racial and ethnic minority categories[13] in order to get larger sample sizes. Rates are also presented on an aggregate, statewide basis, rather than a Plan by Plan basis, again to get significant samples.

33. White & Minority Satisfaction Rates	% 'satisfied' with: Health Care	Health Plan	Doctor	Specialist
White Members[1]	81%	64%	77%	79%
Minority Members[2]	78%	69%	69%	77%

[1] White AND Non-Hispanic
[2] Hispanic AND/OR racial minority

In 2003, Minorities were as satisfied as Whites with their overall healthcare and with their specialists. However, Minorities were -11% less satisfied than Whites with their doctors, and +7% more satisfied with their Health Plans.

D. Complaints are the percentages of members responding that they have called or written to their Health Plans with a complaint or problem within the past 12 months.

34. Complaint Rates

	2001	2002	2003	'02-'03 Change
BCBSRI			12.1%	---
BlueCHiP			15.7%	---
UnitedHealthcare			12.5%	---
Blue Cross -MA			13.8%	---
Rhode Island			12.8%	---
New England			13.8%	---
United States			14.6%	---

In 2003, the first year for data collection, RI's complaint rate was –7% less than the New England rate and –12% less than the U.S. rate.

XI: UTILIZATION REVIEW

Utilization Review (UR) is the process Health Plans use to determine if services to members are medically necessary. Most Health Plans will only pay for covered services if they are medically necessary.

This Section provides statistics for 'UR enrollees' of Health Plans. These enrollees are defined in Regulations as Plan members who reside in RI and Plan members who reside elsewhere and receive their care in the state.

A. Adverse Determinations

Some Health Plans require members to get authorization for covered services before they will pay for them. If a review determines the service is not medically necessary, the Health Plan (or its UR agent) will deny the request (i.e., make an adverse determination). Such reviews may be conducted prospective to, concurrent with, or retrospective to a patient's hospital stay or course of treatment.

35. Adverse Determinations[1] *(per 1,000[2])*

	2001	2002	2003	'02-'03 Change
BCBSRI	4.3	3.7	4.0	*10%*
BlueCHiP	4.6	5.5	5.8	*6%*
UnitedHealthcare	8.5	6.9	6.8	*-1%*
Blue Cross -MA	2.8	2.3	7.3	*226%*
Rhode Island	5.1	4.4	4.8	*9%*

[1] *Includes prospective, concurrent, and retrospective ADs*
[2] *RI residents & non-residents accessing care in RI*

B. Overturned Appeals

When a Health Plan (or its UR Agent) determines a covered service is not medically necessary and denies payment, a member may appeal that decision according to state law. When such an appeal is overturned, it means that the original decision to deny payment was reversed (i.e., the appeal was successful on the part of the member).

36. Overturned Appeals[1] *(per 1,000[2])*

	2001	2002	2003	'02-'03 Change
BCBSRI	1.5	2.4	2.9	*19%*
BlueCHiP	2.2	3.3	4.9	*46%*
UnitedHealthcare	0.6	0.4	2.8	*612%*
Blue Cross -MA	0.1	0.9	0.1	*-90%*
Rhode Island	1.3	2.1	3.0	*41%*

[1] *Includes level 1, level 2, and external Appeals*
[2] *RI residents & non-residents accessing care in RI*

Endnotes:

[1] *The State of the Art in Health Plan Performance Reporting, Kingsley J., Cryan B., HEALTH, March 2002*

[2] *PMPM premium comparisons are not adjusted for differences in benefits packages, co-pays, deductibles, or the claims experiences of the covered members, all of which would affect PMPM premiums*

[3] *Includes full-service Health Plans (excludes vision & dental Plans) with 10,000+ RI members (i.e., BCBSRI, BlueCHiP, UnitedHealthcareHealthcare –NE, Blue Cross –MA)*

[4] *e.g., 'gatekeepers', second opinions, formularies, restricted networks, etc.*

[5] *Raw data extracted from the NAIC-Health (annual statement) database using Highline Data software. 2003 benchmarks included 452 Plans nationally and 36 Plans in New England. 2002 benchmarks included 434 Plans nationally and 35 Plans in New England.*

[6] *Underwriting healthcare coverage is the primary function of Health Plans and the Statutory regulatory filings, the source for enrollment and financial data, reflect this activity only*

[7] *The first three metrics in this Section are not all inclusive of all revenue and expenses that may be reported on the Statutory filings, so one cannot necessarily deduct the two expense metrics (i.e., Medical & Administrative) from the Revenue metric (Premium Revenue) and arrive at the Profitability metric*

[8] *HEDIS (Health Plan Employer Data and Information Set) is a set of performance measures for the managed care industry, administered by the National Committee for Quality Assurance (NCQA)*

[9] *Almanac of Hospital Financial and Operating Indicators, 2004 Ed., Ingenix, (pp 241 & 409)*

[10] *Includes: four DTaP/DT, three IPV, one MMR, three HIB, three hepatitis B, and one VZV vaccinations*

[11] *Includes: the second MMR, three hepatitis B, and one VZV vaccinations*

[12] *CAHPS (Consumer Assessment of Health Plans) is a set of standardized surveys assessing patient satisfaction and is administered by the NCQA.*

[13] *Includes: African Americans, Asians, Native Indians, Pacific Islanders, and Hispanics*